www.sunrisedental.com
855.228.2336

SUNRISE DENTAL

Acknowledgement of Receipt of Statement of Policy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of SUNRISE DENTAL. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office healthcare operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties to this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

SUNRISE DENTAL reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices changes, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	**YES**	**NO**
SPOUSE ONLY	**YES**	**NO**
OTHER (PLEASE SPECIFY)	**YES**	**NO**

_____ _____

Name of Patient or Responsible Party Signature of Patient or Responsible Party

_____ _____

Date Description of Responsible Party's Authority

OFFICE USE ONLY

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided prior to treatment? Yes No Date Provided: _____

Reason for Denial: Need more time to review statement of Privacy Practices.
Wanted to consult with another person, before signing.
Unable to sign.
Reason not given.
Other (explain): _____